



SOSY Student Services Plan

Name _____

Date _____

Location _____

☐ Here-to-Work

☐ Recovery

Instructional

<input type="checkbox"/> ESL Instruction Focus/Goal(s):	Materials:
<input type="checkbox"/> Life Skills Focus/Goal(s):	Materials:
<input type="checkbox"/> Career Awareness/Vocational Training Focus/Goal(s):	Materials:
<input type="checkbox"/> Pre-GED Preparation Focus/Goal(s):	Materials:
<input type="checkbox"/> GED Preparation Focus/Goal(s):	Materials:
<input type="checkbox"/> Credit Recovery Focus/Goal(s):	Materials:
<input type="checkbox"/> Other Focus/Goal(s):	Materials:

Supportive

<input type="checkbox"/> Nutrition	<input type="checkbox"/> Dental check-ups
<input type="checkbox"/> Transportation	<input type="checkbox"/> Hearing Screenings
<input type="checkbox"/> Translation	<input type="checkbox"/> Vision Exams
<input type="checkbox"/> Material Resources	<input type="checkbox"/> Other _____
<input type="checkbox"/> Counseling leading to re-enrollment in School	<input type="checkbox"/> Other _____

Planned Methods of Supportive Service Delivery

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Schedule of Planned Support

Days:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Times:							